Ventilator Physician's Order Form

Please complete this form giving sufficient detail to enable the Prior Approval Unit to review the** request **for** SNF **Placement.

Recipient Information **DMA-0008**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Provider Information

6. Receiving Facility Name:_____
7. Receiving Provider #:_____NPI: ☐ Atypical: ☐ 8. Taxonomy: _____
9. Address: _____ 10. Nine Digit Zip Code: _____

Requester Contact Information

Name:_____ Phone #:_____ Ext:_____

Medical Information

11. Date of onset for ventilator dependence: _____
12. Number of hours of ventilator usage:_____ 13. Vent Type: _____
14. Ventilator settings: _____
15. Patient Stable? ☐ Yes ☐ No without Infections or extreme ventilator changes in ventilatory settings and/or duration. (i.e. increase in respiratory rate by 5 breaths per minute, increase in FIO_2 of 25% or more, and/or increase in tidal volume of 200 mls or more)
16. Potential to wean off ventilator: ☐ Yes ☐ No

Related Medical History:

Prognosis and remarks:

Ventilator Addendum completed by:

_____ _____ _____
Name **Title** *(Must be MD,RNP, PA)* **Date**

_____ _____
Location **Telephone Number**

Fax this form to CSC at: (855) 710-1964

Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp